WELCOME

1 About Your Child

Today's Date: ____/____/____ File #:_____

Child's Name: _____
LAST FIRST M.I.

Child's Nickname: _____ ❑ Boy ❑ Girl

Child's Birthdate: ____/____/____ Age: _____

School: _____ Grade: _____

Child's Home Phone #:(____) _____

Child's SS#: _____

Child's Address: _____
HOME ADDRESS

_____
CITY STATE ZIP

Referred By: _____
(If doctor, please give address & phone number.)

_____

2 Insurance Information

Primary Dental Insurance

Co. Name: _____

Address: _____

_____
CITY STATE ZIP

Phone #: _____

Insured's ID#: _____

Group # (Plan, Local, or Policy #): _____

Insured's Name: _____

Relation: _____ Date of Birth: ___/___/___

Insured's Employer: _____

Does either policy cover Orthodontics? ❑ Yes ❑ No

Secondary Dental Insurance

Co. Name: _____

Address: _____

_____
CITY STATE ZIP

Phone #: _____

Insured's ID#: _____

Group # (Plan, Local, or Policy #): _____

Insured's Name: _____

Relation: _____ Date of Birth: ___/___/___

Insured's Employer: _____

3 Child's Family Information

Who is accompanying this child today?

_____ _____
FULL NAME (IF OTHER THAN PARENT) RELATION TO CHILD

Do you have Legal Custody of this Child? ❑ Yes ❑ No

How many Brothers/Sisters? _____ Age(s): _____ _____ _____

Mother's Name: _____
❑ STEP MOTHER ❑ GUARDIAN

_____
(❑ **CHECK IF SAME AS CHILD'S)** HOME ADDRESS CITY STATE ZIP

(_____)_____ (_____)_____ _____
HOME PHONE # WORK PHONE # EXT.

_____ ____/____/____ _____
MOTHER'S SOCIAL SECURITY # DATE OF BIRTH MOTHER'S DRIVERS LIC. #

Employer: _____ How Long? _____

_____
EMPLOYER'S ADDRESS CITY STATE ZIP

Father's Name: _____
❑ STEP FATHER ❑ GUARDIAN

_____
(❑ **CHECK IF SAME AS CHILD'S)** HOME ADDRESS CITY STATE ZIP

(_____)_____ (_____)_____ _____
HOME PHONE # WORK PHONE # EXT.

_____ ____/____/____ _____
FATHER'S SOCIAL SECURITY # DATE OF BIRTH FATHER'S DRIVERS LIC. #

Employer: _____ How Long? _____

_____
EMPLOYER'S ADDRESS CITY STATE ZIP

4 Account Information

Person ultimately responsible for account

Name: _____ _____
RELATION TO CHILD

Billing Address: _____

_____
CITY STATE ZIP

_____ ____/____/____ _____
SOCIAL SECURITY # DATE OF BIRTH DRIVERS LIC. #

(_____)_____ _____ (_____)_____
WORK PHONE #: EXT. CELL PHONE #:

Payment method: ❑ Cash ❑ Check

_____ /_____
❑ Credit Card - Enter card # above (if accepted)

_____ I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (if offered at this office).
Initials

Please Continue On Back

5 Child's Dental Information

Reason for today's visit: ❑ Exam ❑ Emergency ❑ Consultation

Is Child in pain? ❑ No ❑ Yes How Long?_____

Please indicate ☑ any of the following problems:

❑ Discomfort, clicking or popping in jaw. ❑ Lost/Broken Filling(s) ❑ Stained teeth
❑ Red, swollen or bleeding gums. ❑ Teeth grinding ❑ Locking Jaw
❑ Sensitive tooth, teeth or gums. ❑ Ringing in Ears ❑ Bad breath
❑ Blisters/Sores in or around the mouth. ❑ Broken/Chipped tooth ❑ Loose tooth
❑ Other(s):_____

Does child require pre-medication? ❑ Yes ❑ No ❑ Don't know

Previous Dentist:_____ (_____)_____

Last Dental exam:____/____/____ Last Dental X-rays:____/____/____

Times a day child brushes?_____ Times a week child flosses?_____

Is the child's water fluoridated? ❑ Yes ❑ No

How would you rate the child's smile? **Best** 1 2 3 4 5 6 7 8 9 10 **Worst**

6 Child's Medical History

Is Child taking any of the following medications? ❑ Pain killers (INCLUDING ASPIRIN) ❑ Ritalin ❑ Stimulants
❑ Blood Thinners ❑ Tranquilizers ❑ Insulin ❑ Muscle relaxers ❑ Others:_____

Child's Physician:_____ (_____)_____
DOCTOR'S NAME OR CLINIC NAME PHONE#

_____ Last Medical Exam:____/____/____
ADDRESS CITY STATE ZIP

Does Child have or ever had any of the following diseases, medical conditions or procedures?

Y N Heart Murmur	**Y N** Tonsillitis	**Y N** High/Low Blood Pressure
Y N Rheumatic fever	**Y N** Respiratory Problems	**Y N** Hepatitis
Y N Artificial Heart Valves	**Y N** Asthma/Difficulty Breathing	**Y N** Artificial Bones/Joints/Implants
Y N Congenital Heart defect	**Y N** Blood Transfusion(s)	**Y N** Liver/Kidney/Organ Problems
Y N Scarlet Fever	**Y N** Leukemia/Anemia	**Y N** HIV+/AIDS/ARC
Y N Surgeries/Operations	**Y N** Diabetes/Hypoglycemia	**Y N** Tuberculosis TB
Y N Cancer/Tumors	**Y N** Hemophilia	**Y N** Psychiatric Problems
Y N Chemotherapy	**Y N** Abnormal Bleeding	**Y N** Hyper Active/ADD
Y N Jaw Problems TMJ/TMD	**Y N** Cleft Lip/Palate	**Y N** Fainting/Seizures/Epilepsy
Y N Hearing Problems	**Y N** Birth Defects	**Y N** Cerebral Palsy

Please list any other medical condition(s) child has or ever had:_____

Is Child allergic to: ❑ Latex ❑ Penicillin/Amoxicillin ❑ Tetracycline ❑ Dental Anesthetics (Novocaine)
❑ Aspirin ❑ Food allergies ❑ Other(s):_____

Please rate the child's general health from 1-10:_____ Does child wear contact lenses? ❑Yes ❑No

Has this child ever taken the drug Ritalin? ❑ No ❑ Yes/How long?_____ Child's Blood type:_____

Does this child do any of the following? ❑ Thumb/Finger Sucking ❑ Tongue Thrusting/Sucking
❑ Heavy Snoring ❑ Mouth Breathing ❑ Lip Sucking/Biting

- We invite you to discuss with us any questions regarding our services. The best Dental health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature _____ Date ____/____/____
❑ Parent or Guardian ❑ Other:

UPDATE
(OFFICE USE)

Initials ____ Date ____/____/____
Comments

Initials ____ Date ____/____/____
Comments

Initials ____ Date ____/____/____
Comments

PATIENT CONSENT FORM

I UNDERSTAND THAT I HAVE CERTAIN RIGHTS TO PRIVACY REGARDING MY PROTECTED HEALTH INFORMATION. THESE RIGHTS ARE GIVEN TO ME UNDER THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA). I UNDERSTAND THAT BY SIGNING THIS CONSENT, I AUTHORIZE YOU TO USE AND DISCLOSE MY PROTECTED HEALTH INFORMATION TO CARRY OUT:

- TREATMENT (INCLUDING DIRECT OR INDIRECT TREATMENT BY OTHER HEALTHCARE PROVIDERS INVOLVED IN MY TREATMENT)
- OBTAINING PAYMENT FROM THIRD PARTY PAYERS (E.G. MY INSURANCE COMPANY)
- THE DAY-TO-DAY HEALTHCARE OPERATIONS OF OUR PRACTICE

I HAVE ALSO BEEN INFORMED OF, AND GIVEN THE RIGHT, TO REVIEW AND SECURE A COPY OF YOUR *"Notice of Privacy Practices"*, WHICH CONTAINS A MORE COMPLETE DESCRIPTION OF THE USES AND DISCLOSURES OF MY PROTECTED HEALTH INFORMATION, AND MY RIGHTS UNDER HIPAA. I UNDERSTAND THAT YOU RESERVE THE RIGHT TO CHANGE THE TERMS OF THIS NOTICE FROM TIME TO TIME AND THAT I MAY CONTACT YOU AT ANY TIME TO OBTAIN THE MOST CURRENT COPY OF THIS NOTICE.

I UNDERSTAND THAT I HAVE THE RIGHT TO REQUEST RESTRICTIONS ON HOW MY PROTECTED HEALTH INFORMATION IS USED AND DISCLOSED TO CARRY OUT TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS, BUT THAT YOU ARE NOT REQUIRED TO AGREE TO THESE REQUESTED RESTRICTIONS. HOWEVER, IF YOU DO AGREE, YOU ARE THEN BOUND TO COMPLY WITH THIS RESTRICTION.

I UNDERSTAND THAT I MAY REVOKE THIS CONSENT, IN WRITING, AT ANY TIME. HOWEVER, ANY USE OR DISCLOSURE THAT OCCURED PRIOR TO THE DATE I REVOKE THIS CONSENT IS NOT AFFECTED.

Signed this _____ day of _____, 20_____

Print Patient Name: _____

Relationship to Patient: _____

Signature: _____

Comfort Dental of Fort Wayne
3825 W. Jefferson Blvd.
Fort Wayne, IN 46804